DISCUSS ISSUES WITH THE CLASSIFICATION AND DIAGNOSIS OF SCHIZOPHRENIA   (8 and 16 marks)

Issues surrounding diagnosis of schizophrenia focus on reliability and validity.

The DSM and the ICD are the two main diagnostic classification systems. Issues with reliability might arise as the two systems differ slightly in their criteria and because no physical cause can be measured so diagnosis places emphasis on report symptoms and the interpretation of the symptoms by the psychiatrist which may also vary. Additionally, the DSM requires a person to present at least 2 symptoms for at least 6 months whereas the ICD requires 1 symptom for only 1 month. This puts in question both the reliability and validity because if the criteria are so different, then they cannot fully be diagnosing the same disorder.

Both systems are also being updated regularly so a person diagnosed at one point in time may no longer be diagnosed after an update which questions the validity over time.

The DSM was developed in America and this could also be an issue as a behaviour in one culture may not be regarded as a symptom of schizophrenia in another culture, highlighting the issue of cultural bias.

A further issue is comorbidity, which is when a person is suffering from two or more mental disorders at one time. It occurs, in part, because the symptoms of different mental disorders often overlap with each other. This then raises questions as to why these are thought to be two different disorder when they have many common symptoms and so can affect classification systems' validity.

Issues with the reliability and validity have been shown in several research studies. Firstly Whaley found that the inter-rater reliability between health professionals was as low as 0.11 which means that, when independently assessing patients, the diagnosis was rarely consistent so the diagnostic tools are unreliable.

Additionally, the DSM states that only 1 symptom is required for diagnosis if the delusions are "bizarre". However, what actually constitutes a bizarre delusion is hard to agree on. A study found that when 50 psychiatrists had to differentiate between "bizarre" and "non-bizarre" delusions, they produced an inter-rater reliability of only 0.40, therefore even this diagnosis lacks reliability. Thus attempting to use "bizarre" is reductionist and is simply an attempt to over-simplify something we do not fully understand.

Furthermore, implications into the cultural issues of the diagnostic tools was found by Copeland. He gave a description of a patient to both US and UK psychiatrists and 69% of those in the US diagnosed schizophrenia yet only 2% of those in the UK diagnosed the disorder which suggests the tools are ethnocentric and reduces the reliability between cultures. Similarly, psychiatrists who encounter patients claiming to be surrounded by spirits may view this as a sign of schizophrenia, but in Puerto Rican cultures, for example, such a belief is common. This cultural difference may also be due to the fact that diagnosis is often used more liberally in America than in other countries as their classification systems use broader definitions and so the whole diagnosis of schizophrenia cannot be reliable if there are such significant culture differences.

Rosenhans "being sane in insane places" study also highlights the issues of reliability and validity. When 'normal' people went to psychiatrics claiming to hear voices, they were admitted to hospital. Rosenhan then later rang hospitals saying he was sending pseudopatients and, even though none were actually sent, it resulted in a 21% increase in detection rate, showing that psychiatrists couldn't identify the disorder reliably or consistently. However Rosenhans study is over 40 years old so classification systems have improved since them and may be more reliable that his results showed.

Diagnosis also has little predictive validity as we know that some patients do recover and some do not. As psychiatrists do not fully understand why some do and some don't, it highlights how reductionist the tools are and suggests that the original diagnosis lacks predictive validity as it could not dictate or help with the course of the disorder.

One ethical issue with the use of diagnoses is that people may be labelled and this label may not be fully accurate or valid. The label could then lead them to become stigmatised, it could affect their life such as their employment or it could lead to a self-fulfilling prophecy. However a potential benefit of being labelled is the guidance to appropriate and effective treatment.

Lastly is the issue of gender bias as Winter found that women are more likely to be classed as mentally ill than men. This could be because psychiatrists who are predominantly male may be biased against or insufficiently sensitive to female clients but, either way, it all shows how unreliable and invalid the diagnostic tool are when identifying schizophrenia.

Despite their obvious weaknesses, the classification systems have led to an improvement in the reliability of diagnosis which has benefitted the sufferers and society as it allows appropriate treatment which allows a great majority of schizophrenics to resume a fairly normal life.